

☐ New Application

☐ Information Update

☐ Correspondencia en Español

*You will not have to provide Social Security numbers or immigration status information for any family members who are not asking for PeachCare coverage.*

**PARENT ONE:**

[illegible][illegible]

**CHILD ONE:**

Name																					
		First					M.I.					Last					Sex	Date of Birth			
U.S. Citizen		Yes				No				Race											
Social Security Number																					
Has Health Insurance		Yes				No				Name of Insurance Company											
Policy Number																					
Relationship to Parent # 1:		Child				Stepchild				Grandchild/relative				Other							
Relationship to Parent # 2:		Child				Stepchild				Grandchild/relative				Other							

**CHILD TWO:**

Name															Sex		Date of Birth													
First					M.I.					Last																				
U.S. Citizen		Yes				No				Race																				
Social Security Number																														
Has Health Insurance		Yes				No				Name of Insurance Company																				
Policy Number																														
Relationship to Parent # 1:															Child				Stepchild				Grandchild/relative				Other			
Relationship to Parent # 2:															Child				Stepchild				Grandchild/relative				Other			

**CHILD THREE:**

[illegible]

Is either parent an employee of the State of Georgia, a public school system or the Board of Regents? Yes ☐ No ☐

If yes, please specify \_\_\_\_\_

Is this employment: Full Time ☐ Part Time ☐

Have any children you are applying for lost health insurance coverage (not Medicaid) in the past six months? Yes ☐ No ☐

If yes, explain: \_\_\_\_\_ Last date of coverage: \_\_\_\_\_

Section IV. Provider Selection

I understand that I may receive my medical care through an HMO (if available) or a provider in Georgia Better Health Care. I would like to choose:

Name of GBHC doctor

or Name of HMO

Address

Phone #

You may name your current doctor if he/she participates in Georgia Better Health Care. If you don't make a choice, you will be assigned to a doctor convenient to where you live. You may change your selection later by calling 770-570-3373 (metro Atlanta) or 1-866-211-0950 (Toll-Free).

Section V. Income and Daycare\*

List all income received by parents and children listed on your application. Do not list income for parent who does not live at this address. Do not list income of a legal guardian or other non-parent. Be sure to show the amount of income before taxes and other deductions. Attach an extra sheet if needed.

INCOME	AMOUNT <small>Before Taxes and Other Deductions</small>	HOW OFTEN? <small>(Weekly, Monthly, Every 2 weeks, Etc.)</small>	NAME OF PERSON RECEIVING <small>(Include only income of the children/parents at the address listed on application.)</small>
Current employer's name: _____			
Current employer's name: _____			
Social Security (RSDI)			
Supplemental Security Income			
Workers Compensation			
Pensions or Retirement Benefits			
Child Support <b>(List amount each child receives.)</b>			
Contributions			
Unemployment Benefits			
Other Income, please specify: _____			

\* Do you pay for childcare (or care for an adult who cannot care for himself/herself) so that someone in your household can work?

NAME OF PARENT WHO WORKS	NAME OF CHILD OR ADULT CARED FOR	UNDER THE AGE OF 2? <small>Yes/No</small>	NAME OF DAY CARE OR CAREGIVER	AMOUNT OF PAYMENT	HOW OFTEN? <small>(Weekly/monthly)</small>

Section VI.

Is anyone in the household pregnant? Yes ☐ No ☐ If yes, who? \_\_\_\_\_

Section VII. Certification, Understanding, and Authorization

I certify that the information I have provided on this application is true and correct to the best of my knowledge. I understand that this information will be verified to determine eligibility. I understand wage and salary information supplied by the Georgia Department of Labor may be disclosed to a third party administrator to verify and determine eligibility for PeachCare. I agree to assign to the state all rights to medical support and third party support payments (hospital and medical benefits).

I understand that I must report changes in my income and circumstances within ten (10) days of becoming aware of the change.

PLEASE NOTE: If your child is not eligible for PeachCare, he/she might qualify for Medicaid. Your application will be referred to Medicaid for review. Medicaid offers the same benefits as PeachCare and does not require a premium. Medicaid may be able to assist with unpaid medical bills from the past three months. If your child(ren) is eligible for Medicaid, you must agree to apply for a Social Security number for your child(ren).

Do you have any unpaid medical bills from the past three months? Yes ☐ No ☐ If yes, what month(s) \_\_\_\_\_

I authorize release of personal and financial information to PeachCare for Kids and the Georgia Department of Community Health. I understand that my case may be subject to a quality control review and I agree to cooperate in the review process.

SIGNATURE OF PARENT OR GUARDIAN: (REQUIRED) \_\_\_\_\_ Date \_\_\_\_\_

Where did you get this application: Dr's Office/Hospital ☐ School/Daycare ☐ Church ☐ Health Dept. ☐ Caseworker ☐

I-877-GA-PEACH ☐ Other ☐ \_\_\_\_\_

Once your application has been approved, you will receive a letter letting you know the amount of your monthly premium.

Check/Money Order attached? Yes ☐ No ☐ Amount \_\_\_\_\_

Please mail application to:

PeachCare for Kids  
P.O. Box 2583  
Atlanta, GA 30301-2583

877-427-3224 (Toll-Free)

Eligibility will not be affected by race, color, national origin, age, disability, or sex except where it is required by law.